Roberts, Paul@Wildlife

To: Gilliam, Mikayla@Wildlife; MacCaughey, Nikki@Wildlife

Gilliam, Mikayla@Wildlife <Mikayla.Gilliam@Wildlife.ca.gov>; MacCaughey, Nikki@Wildlife Nikki.MacCaughey@Wildlife.ca.gov

Contacts for HR

Paul Roberts, Supervising Program Technician III
Special Permits Unit
License and Revenue Branch
Department of Fish and Wildlife
(916) 928-5848

Leave Time Contribution Options

savingsplus
CALIFORNIA STATE EMPLOYEE 401(K) & 457(b) PLANS

If you cash out your accumulated unused leave time (Lump Sum Separation Pay) when you retire, it is taxable. Another option is to contribute all or a portion of your Lump Sum Separation Pay into your Savings Plus accounts, which may allow you:

- To maximize your contribution
- To defer your taxes
- The flexibility of how you take payments

Option to spread your contributions
If your last day to work (separate from service) is on or after November 1, you may defer your separation pay into your Savings Plus account into the following tax year. This allows you to potentially maximize contributions for both this and next year.

Catch-up for lost time
You may "catch-up" for the previous years you did not contribute the maximum amount allowed to your 457(b) plan by using your Lump Sum Separation Pay at retirement as a catch-up to maximize your contribution. You can obtain a copy of the Traditional Catch-Up Contribution Guide to see if you qualify on **savingsplusnow.com** or by contacting the Savings Plus Service Center at (855) 616-4776. Then, complete the 457(b) Traditional Catch-Up Form found at **savingsplusnow.com**.

Take action!
Your Lump Sum Separation Pay paperwork must be officially submitted at least five (5) workdays (Monday through Friday, excluding Saturdays, Sundays and legal holidays) prior to separation; however, personnel offices request you submit your paperwork 30 days prior to separation of service in order to accommodate necessary discussions that may impact timely completion of the paperwork. Be sure you:

1. **Complete** the *Lump Sum Separation Pay Contribution Election Form* on the other side of this flier.
2. **Sign and date the Form**.
3. **Attach** your Traditional Catch-Up Approval Letter, if applicable.
4. **Copy** all documents for your personal records.
5. **Submit** all signed and dated forms to your personnel office.

Need help? Contact a Savings Plus Customer Service Representative at (855) 616-4776. They are available to assist you.

Important Notes: If you do not have an investment election on file, your contribution will be deposited into a Target Date Fund based on your date of birth and remain there until you request a different fund option. If you do not set up an account prior to the contribution being deposited, your contribution will be invested in the Target Date Income Fund.

If you already have an account, your elected amount of Lump Sum Separation Pay will be deposited into your investment election for contributions. You may change your investment selection at any time online or over the phone.

401(k) and 457(b) plan contribution limits for tax year 2020

	Maximum contribution limit	Contribution limit plus Age-Based Catch-Up	OR Traditional 457(b) Catch-Up contribution limit[1]
This year, if you are...	...less than age 50	...at least age 50	...3 years or less from your normal retirement age[2]
401(k) Pre-tax/ 401(k) Roth	$19,500	$26,000	$26,000 (use Age-Based Catch-Up)
457(b) Pre-tax/ 457(b) Roth	$19,500	$26,000	$39,000
TOTAL	**$39,000**	**$52,000**	**$65,000**

[1] Individuals cannot use the Traditional 457(b) Catch-Up and Age-Based Catch-Up in the same year, however, an individual can use the Traditional 457(b) Catch-Up in the 457(b) plan and the Age-Based Catch-Up in the 401(k) plan.
[2] You may participate in Traditional Catch-Up during the last three years PRIOR to your Normal Retirement Age. Your Normal Retirement Age is the age you elect between ages 50 (age 55 for PEPRA members) and 70½. If no age has been elected, your Normal Retirement Age will be age 70½.

Source: IRS.gov

savingsplus
CALIFORNIA'S STATE EMPLOYEE 401(k) & 457(b) PLANS

Lump Sum Separation Pay Contribution Election Form

Submit this original completed form to your personnel office at least five (5) workdays (Monday through Friday, excluding Saturdays, Sundays and legal holidays) prior to separation. Be sure to keep a copy for yourself. However, personnel offices request you submit your paperwork 30 days prior to separation of service in order to accommodate necessary discussions that may impact timely completion of the paperwork.

SECTION I-Participant Information

Last Name, First Name, MI: ROBERTS, PAUL D.	
Mailing Address: 5606 Moonlight WAY	
City, State, Zip Code: ELK GROVE, CA 95758	Daytime Telephone Number: 916 203-7503
Separation Date (mm/dd/yyyy): August 1, 2021	Alternate Contact Telephone Number: 916 928-5848

SECTION II- Contribution Information

* A. Write the amount you will have contributed to each plan for the tax year you separate. If SCO is your pay center, your December contribution from the previous year will be included this year. Include all of your future payroll contributions in your contribution calculations as this will impact the amount of Lump Sum Separation Pay you may defer based on annual limits. Keep in mind, if you are separating in December, your December monthly contribution needs to be calculated as part of your current year contributions. Do not include the Lump Sum Separation Pay you will contribute after you separate.

☐ Pre-tax 401(k) Amount $_____ ☐ Roth 401(k) Amount $_____

☒ Pre-tax 457(b) Amount $ 160 ☐ Roth 457(b) Amount $_____

* B. Write the amount you elect to contribute to your Savings Plus account from your Lump Sum Separation Pay in the relevant boxes below.

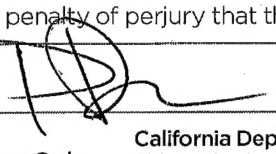
Plan Year	401(k)		457(b)	
	Pre-tax	Roth	Pre-tax	Roth
	$	$	$	$
	$	$	$	$

* The total amount of Section II item A and the amount in item B that is applicable to this tax year cannot exceed the maximum annual contribution limits. Contributions to the 403(b) must be included in calculating 401(k) limits.

SECTION III-Participant Certification

I request a contribution of Lump Sum Separation Pay in accordance with my election above. I take full responsibility for providing my request to my personnel office five (5) workdays prior to my separation date and understand the terms and conditions of deferring all or a portion of my Lump Sum Separation Pay. If applicable, I have attached a copy of my Traditional Catch-Up Approval Letter.

I hereby certify under penalty of perjury that the information on this form is true and accurate to the best of my knowledge.

Signature: 	Date: 4-22-2021

Personnel Office Use Only

Refer to SCO personnel letters applicable to Lump Sum Separation Pay for instructions on completing the separation PAR. Attach this request with a copy of the separation PAR and, if applicable, the Traditional Catch-Up Approval Letter from the employee. Retain a copy with the employee file. ***Do not submit a copy to Savings Plus.***

California Department of Human Resources Privacy Notice on Information Collection (rev. 7/16)

This notice is provided pursuant to the Information Practices Act of 1977. The California Department of Human Resources (CalHR), Savings Plus Program, is requesting the information specified on this form pursuant to California Government Code sections 19993 and 19999.5. The information collected will be used for identification of your account and will be disclosed to the Savings Plus Administrative Services Provider (Nationwide) for processing of your request as indicated on the form. Individuals should not provide personal information that is not requested or required. The submission of all information requested is mandatory unless otherwise noted. If you fail to provide the information requested, CalHR will not be able to process the action(s) indicated on the form as requested.

Department Privacy Policy

The information collected by CalHR is subject to the limitations in the Information Practices Act of 1977 and state policy. For more information on how we care for your personal information, please read our Privacy Policy at https://www.calhr.ca.gov/pages/privacy-policy.aspx.

Access to Your Information

The CalHR Privacy Officer is responsible for maintaining collected records. You have a right to access records containing your personal information we maintain. To request access, contact: CalHR Privacy Officer, 1515 S Street 400N, Sacramento, CA 95811/(916) 324-0455 / CalHRPrivacy@calhr.ca.gov

NRM-13436CA-CA.6

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 07/2020)

D

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

1. TYPE OF ACTION

- ☐ **NEW** - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*
- ☐ **CANCEL** – *(Complete Sections A, C, D)*
- ☐ **CHANGE** - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*
- ☐ **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

2. NAME *(First)* *(Middle)* *(Last)*

Paul Dale Roberts

ADDRESS *(Number and Street)*

5606 Moonlight Way

(City, State, and Zip)

Elk Grove, CA 95758

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE ☐

4. MARITAL STATUS ☒ MARRIED ☐ SINGLE ☐ DOMESTIC PARTNER

5. GENDER ☒ MALE ☐ FEMALE ☐ NONBINARY

6. SOCIAL SECURITY NUMBER

565-94-8441

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER

SECTION B

1. NAME OF DENTAL PLAN

Delta Dental

2. PROVIDER/FACILITY NUMBER *(If applicable) (prepaid plans only)*

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDES THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self) (First) (Middle) (Last)	DATE OF BIRTH (MM/ DD/ YY)	FAMILY RELATIONSHIP	GENDER
	Paul Dale Roberts	1-17-55	SELF	Male
	SSN 565-94-8441			
	Deanna Jaxine Stinson	10-12-86	Wife	Female
	SSN 619-26-9499			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

- ☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*
- ☐ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.
- ☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy)*

3. DATE SIGNED

1-19-2021

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED.CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
☐ CSU-150 ☐ NON-CSU-351			MONTH YEAR	$	$			$

COMPLETE ON CHANGES ONLY			12. PERMITTING EVENT DATE (MM / DD /YY)	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (*IF RETIRED*)
10. PRIOR EMPLOYER DED. CODE ☐ CSU-150 ☐ NON-CSU-351	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	MONTH DAY YEAR		MONTH DAY YEAR -1-			☐ AGENCY ☐ CALPERS RETIREE

18 REMARKS

19. SIGNING PERSONNEL OFFICER'S NAME *(Please Print)*

20. AUTHORIZED AGENCY SIGNATURE

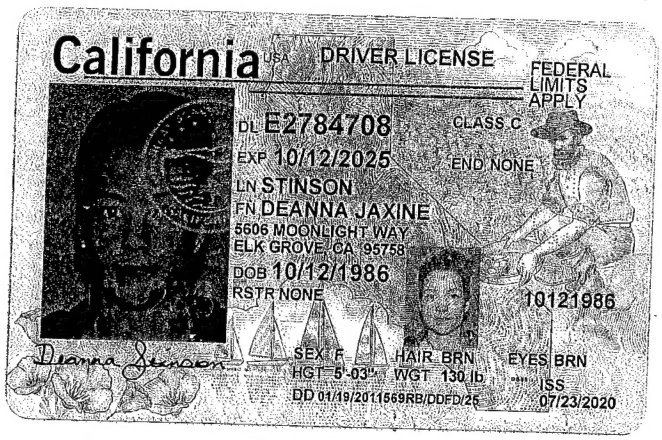
I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employees named herein is eligible for enrollment in the State Dental Insurance Program.

21. TELEPHONE NUMBER *(Include Area Code)*

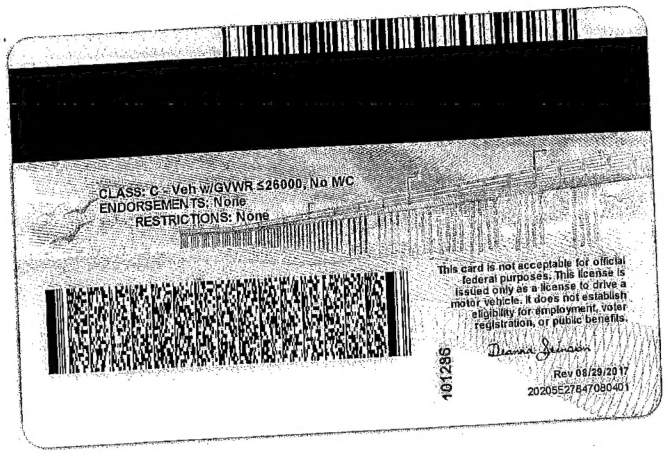
22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year

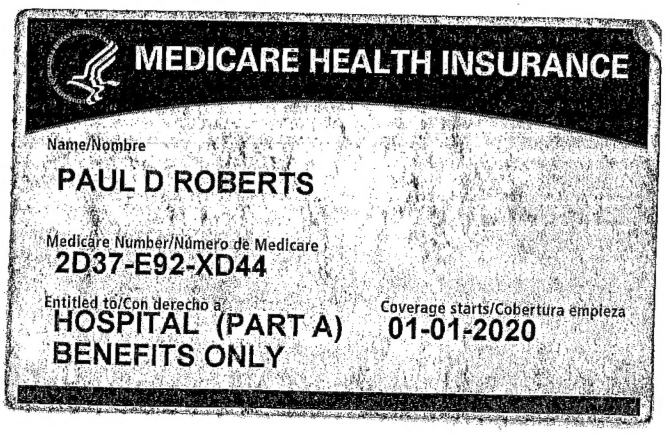
23. EMAIL ADDRESS

Distribute one copy each to Controller, Carrier, Agency, and Employee



HR FAX
916 651-7655


CLASS: C - Veh w/GVWR ≤26000, No M/C
ENDORSEMENTS: None
RESTRICTIONS: None
This card is not acceptable for official federal purposes. This license is issued only as a license to drive a motor vehicle. It does not establish eligibility for employment, voter registration, or public benefits.
Dennis Johnson
101286
Rev 08/29/2017
20205E27847080401


MEDICARE HEALTH INSURANCE
Name/Nombre
PAUL D ROBERTS
Medicare Number/Número de Medicare
2D37-E92-XD44
Entitled to/Con derecho a
HOSPITAL (PART A)
BENEFITS ONLY
Coverage starts/Cobertura empieza
01-01-2020

State of Nevada

Marriage Certificate

NO. MA14-2243

DOC 2014302364
04/21/2014 10:58:06 AM
Requested By
WILLIAM K OLDS
Washoe County Recorder
Lawrence R. Burtness - Recorder
Page 1 of 1

State of Nevada } ss.
County of Washoe }

This is to certify that the undersigned, Officiant (Title)

did on the 14th day of April, 2014

at ARCH OF RENO WEDDING CHAPEL, RENO (Address or Church) (City) Nevada,

join in lawful wedlock PAUL DALE ROBERTS

of ELK GROVE (City) State/Country of CALIFORNIA

Date of Birth 01/17/1955, and DEANNA JAXINE STINSON

of ELK GROVE (City) State/Country of CALIFORNIA

Date of Birth 10/12/1986, with their mutual consent, in the presence of

[redacted] and

[redacted], witnesses.

SEAL OF WASHOE COUNTY STATE OF NEVADA

William K. Olds

Signature of person performing marriage

William K. Olds, Minister

Print name under signature

Officiant

Official title of person performing the marriage

Nancy L. Pavet
WASHOE COUNTY CLERK

Couple's Mailing Address:
5606 MOONLIGHT WAY
ELK GROVE, CA 95758

MINISTER OR JUDGE: YOU MUST PRESENT THIS ORIGINAL DOCUMENT WITHIN 10 DAYS TO:
WASHOE COUNTY RECORDER, P.O. BOX 11130, 1001 E. 9TH STREET, RENO, NV 89520-0027

By the raised Washoe County Recorder seal on this page, I certify that this document is a correct copy of the original recorded in my office.

Lawrence R. Burtness By [signature] DEPUTY RECORDER / DATE 4/21/14

Lawrence R. Burtness, County Recorder, Washoe County, Nevada

22222	a Employee's social security number 565-94-8441	OMB No. 1545-0008	
b Employer identification number (EIN) 94-6001347		1 Wages, tips, other compensation 51,364.88	2 Federal income tax withheld 5,398.81
c Employer's name, address, and ZIP code STATE OF CALIFORNIA BETTY T. YEE, CALIFORNIA STATE CONTROLLER P.O. BOX 942850 SACRAMENTO, CA 94250-5878		3 Social security wages 55,885.20	4 Social security tax withheld 3,464.87
		5 Medicare wages and tips 55,885.20	6 Medicare tax withheld 810.33
		7 Social security tips	8 Allocated tips
d Control number		9	10 Dependent care benefits
e Employee's first name and initial Last name Suff. P D ROBERTS 5606 MOONLIGHT WAY ELK GROVE CA 95758		11 Nonqualified plans	12a Code G 240.00
		13 Statutory employee ☐ Retirement plan ☒ Third-party sick pay ☐	12b Code DD 17,001.36
		14 Other	12c Code
			12d Code
f Employee's address and ZIP code			

15 State	Employer's state ID number	16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax	20 Locality name
CA	80040397	51,364.88	1,783.84			

Form **W-2** Wage and Tax Statement 2019

Department of the Treasury—Internal Revenue Service

Copy 1—For State, City, or Local Tax Department

Send Completed Form to:
VSP Attn: Client Administrative Services, MS 422
PO Box 997100
Sacramento, CA 95899-7100
Email: stateofca@vsp.com
Fax: 916.389.8304

Retiree Vision Plan Enrollment

California Department of Human Resources
State of California

NOT FOR OPEN ENROLLMENT USE

A. Retiree Information

Employee Name (First, MI, Last)	Social Security Number	Date of Birth
PAUL D. ROBERTS	565-94-8441	1-17-55

Mailing Address (Number and Street)	City	State	Zip Code
5606 Moonlight WAY	ELK GROVE	CA	95758

Type of Action: ☐ New Enrollment ☐ Change ☐ COBRA ☐ Cancel

Choose Vision: ☐ Premier Plan ☐ Basic Plan

Telephone #: 916 203-7503

B. Enrollment Election

☒ I elect to enroll in a vision plan as shown above and authorize deduction to be made from my retirement warrant by my retirement system to cover my share of the cost of enrollment as it is now or may be in the future. Furthermore, the vision plan vendor is authorized to transmit and my retirement system is authorized to accept enrollment data from the vision plan vendor. My retirement system shall consider my appearance on enrollment data in any form from the vision plan vendor as my authorization and agreement to initiate and make continuing deductions from my retirement warrant for payment of premiums for a minimum twelve month period. I understand that depending on the enrollment date, my enrollment period may be greater than twelve months.

☐ I do not wish to enroll into any Retiree Vision Plan.

I have read and understand the general terms of enrollment. (See reverse side - page 2)

Retiree's Signature _____ Date Signed 1-19-2021

C. Dependent Information

Name	Relationship	SSN	Date of Birth
DEANNA Jaxine Stinson	WIFE	619-26-9499	10-12-1986

If more dependents, attach additional pages; only eligible, authorized dependents may use the plan.

D. For Employing Agency Use Only

1. Deduction Code	2. Party Code	3. Retiree Premium Deduction	4. Effective Date of Enrollment	5. BU/CBID at retirement
475				

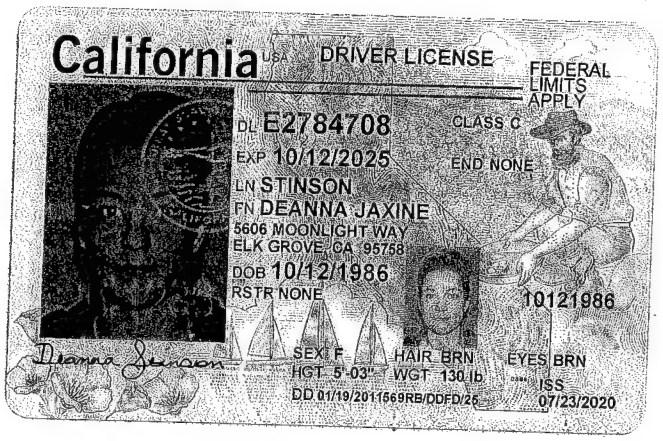
6. Permitting Event Date	7. Permitting Event Code	8. Agency Name

9. Unit Code	10. Agency Code	11. Separation Date	12. Retirement Date	13. Agency Phone Number

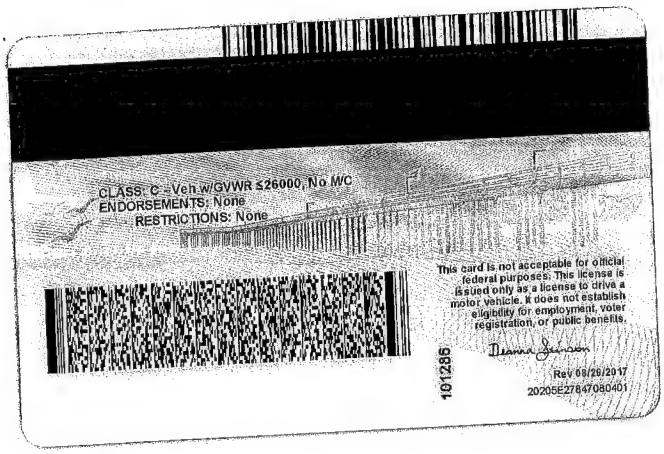
11. I hereby certify under penalty of perjury as follows: I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment into the State Retiree Vision Plan.

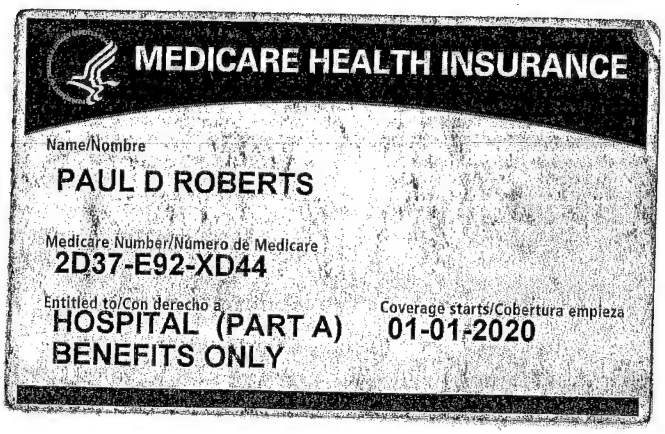
Name: _____ Signature: _____ Date: _____

1 copy to Vendor, 1 copy to Employing Agency, 1 copy to Retiree



HR FAX
916 651-7655


CLASS: C - Veh w/GVWR ≤26000, No M/C
ENDORSEMENTS: None
RESTRICTIONS: None
This card is not acceptable for official federal purposes. This license is issued only as a license to drive a motor vehicle. It does not establish eligibility for employment, voter registration, or public benefits.
Rev 08/26/2017
20205E27847080401
101286


MEDICARE HEALTH INSURANCE
Name/Nombre
PAUL D ROBERTS
Medicare Number/Número de Medicare
2D37-E92-XD44
Entitled to/Con derecho a
HOSPITAL (PART A)
BENEFITS ONLY
Coverage starts/Cobertura empieza
01-01-2020

State of Nevada

Marriage Certificate

NO. MA14-2243

DOC 2014302364
04/21/2014 10:58:06 AM
Requested By
WILLIAM K OLDS
Washoe County Recorder
Lawrence R. Burtness - Recorder
Page 1 of 1

State of Nevada } ss.
County of Washoe }

This is to certify that the undersigned, Officiant (Title)

did on the 14th day of April, 2014

at ARCH OF RENO WEDDING CHAPEL, RENO (Address or Church) (City) Nevada,

join in lawful wedlock PAUL DALE ROBERTS

of ELK GROVE (City) State/Country of CALIFORNIA

Date of Birth 01/17/1955, and DEANNA JAXINE STINSON

of ELK GROVE (City) State/Country of CALIFORNIA

Date of Birth 10/12/1986, with their mutual consent, in the presence of

[signature] and

_____, witnesses.

SEAL OF WASHOE COUNTY STATE OF NEVADA

William K. Olds
Signature of person performing marriage

William K. Olds, Minister
Print name under signature

Officiant
Official title of person performing the marriage

[signature]
WASHOE COUNTY CLERK

Couple's Mailing Address:
5606 MOONLIGHT WAY
ELK GROVE, CA 95758

MINISTER OR JUDGE: **YOU** MUST PRESENT THIS **ORIGINAL** DOCUMENT **WITHIN 10 DAYS** TO:
WASHOE COUNTY RECORDER, P.O. BOX 11130, 1001 E. 9TH STREET, RENO, NV 89520-0027

By the raised Washoe County Recorder seal on this page, I certify that this document is a correct copy of the original recorded in my office.

Lawrence R. Burtness By [signature] DEPUTY RECORDER / DATE 4/21/14

Lawrence R. Burtness, County Recorder, Washoe County, Nevada

22222	a Employee's social security number 565-94-8441	OMB No. 1545-0008	
b Employer identification number (EIN) 94-6001347		1 Wages, tips, other compensation 51,364.88	2 Federal income tax withheld 5,398.81
c Employer's name, address, and ZIP code STATE OF CALIFORNIA BETTY T. YEE, CALIFORNIA STATE CONTROLLER P.O. BOX 942850 SACRAMENTO, CA 94250-5878		3 Social security wages 55,885.20	4 Social security tax withheld 3,464.87
		5 Medicare wages and tips 55,885.20	6 Medicare tax withheld 810.33
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e Employee's first name and initial Last name Suff. P D ROBERTS 5606 MOONLIGHT WAY ELK GROVE CA 95758		11 Nonqualified plans	12a Code G 240.00
		13 Statutory employee ☐ Retirement plan ☒ Third-party sick pay ☐	12b Code DD 17,001.36
		14 Other	12c Code
			12d Code
f Employee's address and ZIP code			

15 State	Employer's state ID number	16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax	20 Locality name
CA	80040397	51,364.88	1,783.84			

Form **W-2** Wage and Tax Statement 2019

Department of the Treasury—Internal Revenue Service

Copy 1—For State, City, or Local Tax Department

Form Approved
OMB No. 0938-0787
Expires: 06/2023

REQUEST FOR EMPLOYMENT INFORMATION

WHAT IS THE PURPOSE OF THIS FORM?

In order to apply for Medicare in a Special Enrollment Period, you must have or had group health plan coverage within the last 8 months through your or your spouse's current employment. People with disabilities must have large group health plan coverage based on your, your spouse's or a family member's current employment.

This form is used for proof of group health care coverage based on current employment. This information is needed to process your Medicare enrollment application.

The employer that provides the group health plan coverage completes the information about your health care coverage and dates of employment.

HOW IS THE FORM COMPLETED?

- Complete the first section of the form so that the employer can find and complete the information about your coverage and the employment of the person through which you have that health coverage.
- The employer fills in the information in the second section and signs at the bottom.

WHAT DO I DO WITH THE FORM?

Fill out Section A and take the form to your employer. Ask your employer to fill out Section B. You need to get the completed form from your employer and include it with your Application for Enrollment in Medicare (CMS-40B). Then you send both together to your local Social Security office. Find your local office here: **www.ssa.gov**.

GET HELP WITH THIS FORM

- **Phone:** Call Social Security at **1-800-772-1213**
- **En español:** Llame a SSA gratis al **1-800-772-1213** y oprima el 2 si desea el servicio en español y espere a que le atienda un agente.
- **In person:** Your local Social Security office. For an office near you check **www.ssa.gov**.

Sent to:
Mikayla Gilliam
Personnel Specialist
CDFW - Human Resources Branch
PO Box 944209
Sacramento, CA
94299

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name: California Dept of Fish + Wildlife
2. Date: 04 / 20 / 2021
3. Employer's Address: 1740 N. Market Blvd
City: Sacramento
State: CA
Zip Code: 95834
4. Applicant's Name: Paul Dale Roberts
5. Applicant's Social Security Number: 565 - 94 - 8441
6. Employee's Name: Paul Dale Roberts
7. Employee's Social Security Number: 565 - 94 - 8441

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan? ☐ Yes ☐ No
2. If yes, give the date the applicant's coverage began. (mm/yyyy) ☐☐ / ☐☐☐☐
3. Has the coverage ended? ☐ Yes ☐ No
4. If yes, give the date the coverage ended. (mm/yyyy) ☐☐ / ☐☐☐☐
5. When did the employee work for your company?
From: (mm/yyyy) ☐☐ / ☐☐☐☐
To: (mm/yyyy) ☐☐ / ☐☐☐☐
Still Employed: (mm/yyyy) ☐☐ / ☐☐☐☐
6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.
From: (mm/yyyy) ☐☐ / ☐☐☐☐
To: (mm/yyyy) ☐☐ / ☐☐☐☐

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? ☐ Yes ☐ No
2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☐ No
3. Date reserve hours ended or will be used? (mm/yyyy) ☐☐ / ☐☐☐☐

All Employers:

Signature of Company Official
Date Signed ☐☐ / ☐☐ / ☐☐☐☐
Title of Company Official
Phone Number (☐☐☐) ☐☐☐ - ☐☐☐☐

STEP BY STEP INSTRUCTIONS FOR THIS FORM

SECTION A:
The person applying for Medicare completes all of Section A.

1. **Employer's name:**
   Write the name of your employer.
2. **Date:**
   Write the date that you're filling out the Request for Employment Information form.
3. **Employer's address:**
   Write your employer's address.
4. **Applicant's Name:**
   Write your name here.
5. **Applicant's Social Security Number:**
   Write your Social Security Number here.
6. **Employee's Name:**
   If you get group health plan coverage based on your employment, write your name here. If you get group health plan coverage through another person, like a spouse or family member, write their name.
7. **Employee's Social Security Number:**
   If you get group health plan coverage based on your employment, write your Social Security Number here. If you get group health plan coverage through another person, like a spouse or family member, write their Social Security Number.

Once you complete Section A:
Once Section A is completed, give this form to your employer to complete Section B. Once Section B has been completed by your employer, return this form along with your Part B application to your local Social Security office.

SECTION B:
The employer completes all of Section B.

If you're an employer without an hours bank arrangement, complete the section called "For Employer Group Health Plans ONLY"

1. **Is (or was) the applicant covered under an employer group health plan?**
   Please check yes or no if the applicant was covered under your group health plan offered by your company. The applicant may be the employee or another person related to the employee, such as a spouse or family member with disabilities. If your company doesn't offer a group health plan, please check No. A group health plan is any plan of one or more employers to provide health benefits or medical care (directly or otherwise) to current or former employees, the employer, or their families.
2. **If yes, give the date the coverage began.**
   Write the month and year the date the applicant's coverage began in your group health plan.
3. **Has the coverage ended?**
   Check yes or no if the group health plan coverage for the applicant has ended.
4. **If yes, give the date the coverage ended.**
   Write the month and year the group health plan coverage ended for the applicant.
5. **When did the employee work for your company?**
   Write the start and end dates of the employment for the employee in which the applicant is related. It may be the applicant or another person related to the employee, such as a spouse or family member with disabilities.

   Enter the month and year of the start of the employment in the "From" box.

   Enter the month and year of end of the employment in the "To" box.

   If the employee is still employed, enter the month and year of the current date.

   Current employment is active working status. It is not disability or retirement.
6. **If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.**
   Write the start and end dates that your group health plan was primary payer for the applicant.

If you're an employer with an hours bank arrangement, complete the section called "For Hours Bank Arrangements ONLY"

1. **Is (or was) the applicant covered under an hours bank arrangement?**
   Please check yes or no if the applicant was covered under an hours bank arrangement. If you check no, please also fill out the section for "Employer Group Health Plans ONLY".
2. **If yes, does the applicant have hours remaining in reserve?**
   Please indicate if the applicant currently has health coverage based on the remaining hours in the employee's hours bank account.
3. **Date reserve hours ended or will be used?**
   Please write the month and year for when the remaining hours in the employee's hours bank account expired or will expire.

All employers need to complete the bottom of Section B.

- **Signature of Company Official:**
  An official representative of the company needs to sign this document. Please do not print.
- **Date Signed:**
  Write the date that you sign the form in this field.
- **Title of Company Official:**
  Print the title of the company official who signed the form in this field.
- **Phone Number:**
  Write the phone number of the company official who signed the form in this field. If there are questions regarding the information on this form, a representative from Social Security will contact you.